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ABSTRACT

Suicide is the second leading cause of death among adolescents and young adults between the ages of 15-25. Every day, over 1,000 young adults attempt to destroy themselves. Although adolescents contemplate suicide for many reasons, research suggests that depression is the number one risk factor in suicide. Accordingly, this paper describes many of the stressors which have been linked to adolescent suicide, including rising divorce rates, single parent households, social pressures, population growth, reduced family support, and the pressures on teenagers to succeed in the face of economic difficulties. It also provides information regarding the developmental period of adolescence, along with guidelines and rationale for prevention, crisis management, and postvention programs that counselors can plan and implement in a school setting. (Author/TE)

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Adolescent Suicide:
Prevention, Postvention
And
Crisis Management

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Running head: ADOLESCENT SUICIDE:PREVENTION,POSTVENTION

Abstract

Suicide is the second leading cause of death among adolescents between the ages of 15-25. Everyday over 1,000 young adults attempt to destroy themselves. There are many reasons why adolescents contemplate suicide. Research suggests that depression is the number one risk factor in suicide.

The purpose of this paper is to provide the reader with information regarding the developmental period of adolescence as well as information which investigates the characteristics and risk factors associated with the suicidal adolescent. The paper further provides an outline and rationale for prevention, crisis management and postvention programs which can be implemented in a school setting.

Adolescence is a time of great physical, mental and emotional change. When young people pass through this period between childhood and adulthood, they often become confused and their thinking is distorted (Woodruff, 1987). Because society places contradictory demands on adolescents, normal developmental adjustment problems can cause unmanageable stress (Valente, Saunders and Street, 1988).

Suicide is the second leading cause of death among adolescents in the United States. The rates of suicide among adolescent youth currently are higher than ever recorded. Research shows that an estimated 500,000 young people between the ages of 15 and 24 attempt suicide each year and, unfortunately, 5,000 succeed (Neiger & Hopkins, 1988).

From these statistics, it becomes evident that adolescent suicide has reached epidemic proportions. With the increase of suicide among this particular age group, it has become important for parents, teachers, counselors and all those involved with young people to be able to understand how to deal effectively with those adolescents who exhibit suicidal tendencies.

The purpose of this paper is to provide information which examines the developmental issues and predictors that influence teenage suicide. Also, it will scrutinize

the factors and warning signs leading to suicide. Finally, since there is a compelling need for prevention, crisis management and postvention programs, this paper will provide guidelines to implement such plans in a school system.

REVIEW OF LITERATURE

Origins and Predictors of Teen Suicide

In order to understand the predictors of teenage suicide, it is imperative to have an understanding of the developmental origins of adolescence. A fundamental guiding principle about adolescence is that it is a stage of development which is enhanced by a stable, supportive environment within and outside the home. Adolescents need this support as an anchor against which they can work out the enormous uncertainties with which they so often struggle (Giovacchini, 1981).

Adolescence is, perhaps, the most challenging and complicated period of one's life. It is a time during which many developmental changes take place. Individuals experience changes in the way they think, appear and behave. Also, it is a period of transition from the secure and dependent life of a child to the insecure and independent life of an adult. In preparation for life as an adult, adolescents begin to establish their own identities and, in the process, are faced with many questions that only they can answer and many decisions that only they can make (Ziegler & Stevenson, 1987).

Teenagers experience strong feelings of stress, confusion, self-doubt, pressure to succeed, financial uncertainty and other fears of growing up. Children are growing up in a world much different than that of their parents. In the past, the extended family offered a buffer for families experiencing disorganization or stress; today, families have become more mobile, moving frequently due to job advancement or in search of new employment. Fifty million Americans change their place of residency each year and this mobility threatens the existence of the extended family and its support. With mobility, families seem to be experiencing more alienation and isolation (Capuzzi & Golden, 1988). The causes of alienation are rooted in the ambivalence of adolescents and the transformation taking place in our society (Woodruff,1987).

Such changes may foster a sense of loss of control. In some cases, changes are more relevant to specific periods of development. Adolescents, then, may be the group that is most affected by societal changes (Neiger & Hopkins, 1988).

Research suggests that there is no one particular type of teenager who commits suicide; however, there are certain characteristics that tend to increase the risk of suicide. The most common symptom or characteristic behavior of the suicidal adolescent is depression.

A history of depression makes one vulnerable to suicidal ideation (Neiger & Hopkins, 1988). The estimate is that between 45 and 75 percent of those who commit or attempt suicide show previous signs of depression. The suicidal adolescent experiences a sense of alienation which is manifested as a sense of powerlessness, meaninglessness, isolation, depression, hopelessness, and helplessness (Woodruff, 1987).

A child's home environment is the most significant factor in suicidal proneness. Our society is marked by the degeneration of the family, a decline in stable family life, a continuing rise of divorce and increasing mobility (Capuzzi & Golden, 1988). Change, in itself, becomes a stress factor for adolescents. The very nature of the family is changing. Children are likely to experience more than one family pattern during their development. It has been estimated that 25 percent of all children will be part of a remarried family and that many others will live in common-law families. Approximately three-fourths of all marriages end in divorce, and one out of every six children lives with a single parent (Capuzzi & Golden, 1988).

Changes in the family structure such as these are accompanied by inherent stress. Adolescents find these changes difficult. Research has suggested that changes in the quality of family life have contributed to the

rise in adolescent suicide (Capuzzi & Golden, 1988). Research has shown that the number one reason for suicides by adolescents is dysfunctional families (Capuzzi & Gross, 1989).

Another factor of risk is alcohol and drug abuse. These substances lower inhibitions and increase the risk of suicide because the adolescent is more likely to act on impulse. Statistics reveal that approximately 90 percent of all teens have tried alcohol and one out of every three children comes from affected homes where one or both parents are abusers. In 1988, The National Institute on Alcohol and Alcoholism reported that 1.3 million American teens between the ages of 12 and 17 have some problem with alcohol (Grollman, 1988). Alcoholism is associated with 20 to 30 percent of the general suicides; among young people it is as high as 50 percent or more. Grollman (1988) reported that approximately 80 percent of all successful suicides are alcohol or drug related; and a high percentage of these suicides take place within 24 hours of alcohol consumption.

Adolescents have more free time and less supervision than in the past (Capuzzi & Golden, 1988). Also, some adolescents are at risk when they face disappointments, such as poor grades or social rejection (Grollman, 1988). Furthermore, adolescents who suffer from physical, emotional or sexual abuse also are at risk. Capuzzi & Golden (1988)

reported a history of child abuse for 60 percent of the children who tried to commit suicide. It was further estimated that in 29 percent of the families, one or both parents had attempted suicide.

Adolescents who have made previous suicide attempts also are at high risk. One of the revealing signs of suicidal risk is a prior attempt. Capuzzi (1988) reported that 12 percent of those individuals who attempted suicide will try again and succeed within two years.

Another indicator in suicidal attempt is emotional pain. The pain may build over a period of time or it may be an intense reaction to an event (Kolehmainen & Handwerk, 1986). The adolescent may have been physically or sexually abused and has been living with the memories for a long time. Perhaps, the adolescent is struggling with his or her sexual identity and the pain becomes intense, leading to suicidal ideation. As a result, many adolescents fail to cope with life stresses and become socially withdrawn, experience great difficulty in communicating to others, and often engage in coping behavior that only serves to escalate their feelings of pain (Allberg & Chu, 1990). There are many reasons why an adolescent may commit suicide. Educators need to become aware of some of the warning signs of adolescent suicide (Perrone, 1987).

Factors and Warning Signs Leading to Suicide

Most suicidal adolescents will let their feelings be known to others. Eighty percent of those adolescents who attempt suicide will tell someone about their manifestations before they make the attempt (Coleman, 1987).

When a person makes a suicidal statement, it should be taken seriously. An attempt at suicide is a cry for help and understanding. These students plead for someone whom they trust to listen to their pain, while they struggle with the realities of growing up (Hunter, 1988).

Once it is suspected that someone has a suicidal ideation, the person should be confronted calmly and directly. Ask questions such as, "Are you thinking of suicide?" "How long have you been thinking of suicide?" or "What happened to make life so difficult?" Once the individual confirms the intent to commit suicide, it is wise to inquire about the suicide plan. The more detailed the plan, the higher the risk and the need to refer (Woodruff, 1987). If at all possible, the counselor should try to identify the timing of the precipitated crisis.

Adolescents also may display physical, social and behavioral changes which are distress signals that can set the stage for trouble. One of the warning signs of suicidal depression is that of change in sleeping and eating patterns. The teen may sleep too much or too

little, but always feel fatigued. There may be a sudden change in eating habits; therefore, losing or gaining weight may be an early sign of trouble and depression (Griffin & Felsenthal, 1983). Another warning sign of suicidal behavior is the preoccupation with themes of death which express suicidal thoughts. Adolescents also may give verbal hints, either directly or indirectly, like, "I'm going to kill myself" or "It will be so good to get away from it all." These are attempts, whether conscious or unconscious, to make people around them aware of the pending attempt.

Another indicator may be withdrawal from family and friends. Since friendships and activities usually are important to adolescents, any change in involvement with either may signal danger (Kolehmainen & Handwerk, 1986).

Changes in school performance, lowered grades, truancy, and dropping out of activities are other warning signs of potential suicides. Thus, level of involvement in school is one of the barometers used to measure the emotional health of a teen (Griffin & Felsenthal, 1983).

Use of alcohol and drugs not only exacerbates depression but also affects judgement. Alcohol intensifies aggression, which, when turned against oneself, can result in suicide (Griffin & Felsenthal, 1983).

Sudden mood swings may be another indicator of suicide. Adolescents may experience mood swings over a long period of time, as well as an inability to tolerate frustration and control their own impulses (Griffin & Felsenthal, 1983).

Giving away prized possessions, making a will or other financial arrangements are other indicators of suicide (Allen, 1987). Still other warning signs may include exaggerated efforts to keep busy, a constant need for new and different kinds of risk or thrill-seeking stimulation. Crying, attempts to bring closure to one's affairs or a sudden lift of depression are also implicators (Allen, 1987).

Suicidal adolescents often exhibit extreme ambivalence towards themselves and others. They may demonstrate a lack of coping strategies and poor decision-making abilities (Woodruff,1987).

Intervention

Because the suicidal adolescent may be volatile and impulsive, the need for decisive and quick decision-making on the part of the intervener is important (Capuzzi & Gross, 1989). Taking a strong authoritative role allows the counselor to set goals and boundaries for covering the crisis. It is important that teachers be aware of at-risk students and appropriately refer them on to the

counselor (Alexander, 1988). The first step towards intervention, then, is the recognition that the adolescent has exhibited suicidal clues. One of the primary intervention methods is to be calm and supportive, while actively listening to the adolescent in a non-judgemental way. The more the adolescent talks, the stronger the relationship is apt to become and trust will soon develop. The mere act of communicating these painful emotions is the first step in a long-term healing process. The information that adolescents share will help them to gain more understanding of why they desire to commit suicide (Woodruff, 1987).

If an adolescent has been identified as potentially suicidal, it becomes important to inform the parents, so that they can, first, become aware that the problem exists, and secondly, be able to contact outside resources. Every possible step should be taken to involve the adolescent in ongoing counseling so that steps can be quickly and reactively taken (Capuzzi & Gross, 1989).

Prevention

There is a compelling need in elementary, middle and high schools for prevention, crisis management and postvention programs. One of the greatest myths about suicide is the belief that nothing can be done to

prevent it. The reality is quite different. Providing people with information about options for support and recovery programs is at the heart of suicide prevention (Woodruff, 1987).

In trying to understand adolescent suicide and prevent it before it happens, it is important to keep in mind that the majority of those who attempt suicide do not want to die. Research estimates that 80 percent of the adolescents contemplating suicide will communicate suicidal ideation before they make the attempt (Woodruff, 1987). Adolescent suicide doesn't just happen. Surveys conducted by the National Youth Suicide Center reveal that 77 percent of high school seniors have had at least one friend tell them they were contemplating suicide (Schafer, 1989).

Prevention must include a way to communicate with the potential suicide victim in order to reduce the sense of alienation and isolation, decrease feelings of hopelessness, and raise self-esteem (Alexander, 1988). Schools must become student-centered if they are going to help rather than hurt young people. When schools become places where adolescents can express themselves and talk about their difficulties, they then become more preventive in their role rather than a contributory factor to adolescent suicide (Woodruff, 1987).

Educators, counselors, therapists, and faculty members need to work together to find ways to listen to and understand the plight of adolescents as they try to cope with the demands of growing up in contemporary society. Adolescents can be made to feel like they are less alone when provided with safe ways to express their feelings and feel better about themselves (Alexander, 1988).

School programs significantly can contribute to the prevention of suicide if they are properly administered. The entire staff; including custodians, secretaries, and cafeteria workers should be trained. The minimum objective for a prevention program would be the development of school policy and procedures in the event of a suicide threat, attempt or completion (Alexander, 1988).

Suicide prevention programs must begin early, before children reach adolescence. Preventive programs can be designed to help all students learn effective coping skills. The most important objective of primary prevention would be to help children or adolescents develop coping skills, self-esteem, social skills and dealing with losses and transitions in a school climate that promotes health (Smith, 1988). In pre-adolescent years, this can be taught in the classroom guidance curriculum using the DUSO and Pumsy kits (Smith, 1988). There are many places to integrate a suicide prevention curriculum

into an existing curriculum, such as in health, psychology, or family living units of home economics (Smith, 1988). Prevention programs can further teach students to identify, support, and seek out help for classmates who are at risk for suicide. Everyone who comes in contact with young people should be involved. Teachers need to be aware of the warning signs, as well as their school policy and procedures in the event of a threat of a suicide. Parents need to have an understanding of the importance of communication with their children and learn parenting skills to help their children develop coping skills. Many schools now offer Systematic Training Effective Parenting classes to parents (Smith, 1988). Counselors need to be able to implement crisis intervention techniques, know how to assess the risk for a student attempt, and be familiar with the pertinent referral system (Smith, 1988).

Crisis Management and Postvention

All schools should have written policies on suicide prevention, crisis management and the often overlooked "postvention " that takes place after a suicide has occurred. Schools should have a consultant who is trained in suicide prevention to be available to counselors, teachers and other personnel. Schools need to develop their own core of experts to deal with suicide (Schafer, 1989).

Coping with a suicide begins with a crisis management plan, since the plan helps the program deal with the suicide before it occurs (Schafer, 1989). The crisis management plan can create an effective organizational team for dealing not only with suicide, but also with other crises such as accidents, drug overdoses, riots, earthquakes and other natural disasters.

A crisis team in a school system can function at three levels: individual building, central office and community support groups. The crisis management team should include guidance counselors from each school, a school psychologist, a school social worker, a school nurse, the special education director, principals from each school in the district, and a teacher from each building. The team should be responsible for establishing the plan and should meet at least once a semester to review it. It is important for all members to be aware of who is in charge during the crisis (Phi Delta Kappa, 1988).

The initial step in creating a crisis plan is to write a statement of purpose and a rationale that gives reasons why the procedures are needed. Then, the plan should elaborate the procedures that team members will need to follow if a crisis occurs.

When a suicide occurs, the crisis management plan should be put into action. The following are suggested

guidelines of steps to implement a crisis management plan when a student suicide occurs (Garfinkel, Crosby, Herbert, Maters, Pfiefer, and Sheras, 1988).

The first step is to contain the story and protect the privacy of the family, as the family has suffered a tragic loss. The school has an obligation not to report anything that would be degrading to the family (Phi Kappa Delta, 1988). The next step would be to verify that the suicide occurred. It is necessary to contact the police or coroner's office to get the exact name of the student involved. Statements from teachers or students should be investigated. Explain that it is important that the information come from the front office (Garfinkel et al., 1988). Once the report has been verified, the third step would be to notify the key people on the school crisis team (Garfinkel et al., 1988).

It is important that no statement be made to the media at the building level. Reporters and television crews should be asked to leave the building. It is important to Inform reporters that information will only be available through the superintendent's office. A faculty meeting should be scheduled as soon as possible (Garfinkel et al., 1988). Small groups should be initiated throughout the school in order for students to discuss their feelings. Groups should be no larger

than 15-20 students. Counselors should be on hand to provide individual counseling to those students who desire one-to-one counseling. The crisis management team should arrange for back up services from community agencies when an emergency occurs (Phi Delta Kappa, 1988). Teachers should make themselves available to work with students, parents and community members. The first 48 hours after a student commits suicide are critical.

There may be a need for follow-up activities for both students and faculty. It may be necessary to continue group meetings for bereaved students and staff beyond those initially held at the time of the crisis (Smith, 1988). As mentioned earlier, with the increase of cluster suicides, an intervention plan is important for preventing the needless destruction of young people. When an adolescent has attempted or completed a suicide, it is imperative, particularly in a school setting, to be aware of the impact of such an event on the "system" (Capuzzi & Gross, 1989).

It is most evident, then, that postvention efforts reflect the needs of the students, staff and community. After suicide, individuals and families are likely to suffer shock, denial, guilt, depression and bewilderment (Capuzzi & Gross, 1989). Therefore, the crisis intervention team

needs to provide for the students, faculty, staff, administration and the community.

CONCLUSION

This paper described many of the stressors which have been linked to adolescent suicide, including rising divorce rates, single parent households, social pressures, population growth, reduced family support and the pressures on teenagers to succeed in the face of economic difficulties (Capuzzi & Golden, 1988). It is estimated that the average classroom of thirty students contains sixteen students whose parents are divorced and twenty one students whose parents drink (Grollman, 1988).

Teenage suicide has reached epidemic proportions; therefore, it can no longer be avoided. The research has indicated that suicide is the second leading cause of death among teenagers (Grollman, 1988).

An adolescent who becomes suicidal is communicating the fact that he or she is experiencing difficulty with tasks such as problem-solving, managing stress, or expressing feelings. It is important for adults to respond in constructive, safe, informed ways (Capuzzi & Gross, 1989). A recent national survey revealed that over 70 percent of teens felt suicide could be prevented through a suicide awareness program designed for youths and their parents (Grollman, 1988).

In conclusion, the origins and predictors of teen suicide provide the reader with some factors and warning signs about suicide. The information further describes the responsibility of the counselor in planning for both the prevention of, and reaction to, suicide. As one of the reactive responses, this paper provides the reader with guidelines for implementing a crisis intervention plan in a school setting.

With intervention, many suicides may be prevented. Without intervention, the figures continue to rise. Adolescents, their families, and society all stand to benefit from well conceived and carefully implemented programs that address the suicide issue.

References

Alexander, J.C., & Harmon, R.L. (1988). One counselor's intervention in the aftermath of a middle school student's suicide. Journal of Counseling and Development, 66 (6), 283-285.

Allberg, W.R. & Chu, L. (1990). Understanding adolescent suicide: Correlates in a developmental perspective. The School Counselor, 37 (5), 343-350.

Allen, B.P. (1987). Youth suicide. Adolescence, XXII (86), 271-287.

Berman, A. (1990). Understanding adolescent suicide. The Counselor, 8 (1), 12-15.

Brown, B.H. (1987). Adolescent Suicide: An educator's guide. (Report No. C6021163). Hagerstown, MD: Washington County Board of Education. (Eric Document Reproductive Service No. ED 285-055).

Capuzzi, D., & Gross, D.R. (1989). Youth At Risk: A resource for counselor's, teachers and parents. (1st ed.). Alexandria, VA: American Association for Counseling and Development.

Capuzzi, D., & Golden, L. (1989). Preventing Adolescent Suicide (1st ed.). Muncie, IN : Accelerated Development, Inc.

Coleman, L. (1987). Suicide Clusters. Boston: Faber and Faber.

Garfinkel, B., Crosby, E., Herbert, M., Maters, A.L., Pfiefer, J., & Sheras, P.L. (1988). Understanding and preventing teen suicide: An interview with Barry Garfinkel. Phi Delta Kappa Newsletter, 70 (4), 2-21.

Giovacchini, P. (1981). Urge to Die. New York: Macmilliam.

Grifin, M. & Felsenthal, C. (1983). A Cry For Help. New York: Doubleday & Co.

Grollman, E. (1988). Suicide: Prevention, Intervention, Postvention. Boston: Beacon Press.

Hunter, B.E. (1988). Adolescent suicide: Cries for help. NASSP Bulletin, 72 (10), 92-94.

Kolehmainen, J., & Handwerk, S. (1986). Teen Suicide Minneapolis: Lerner.

Neiger, B.L., & Hopkins, R. W. (1988). Adolescent Suicide: Character traits of high risk teenagers. Adolescence, XXIII (90), 469-474.

Nelson, F.L. (1987). Evaluation of a youth suicide prevention program. Adolescence, XXII (88), 813-825.

Perron, P.A. (1987). Counselor response to adolescent suicide. The School Counselor, 35 (1), 51-56.

Schafer, C. (1989). Suicide prevention in the schools: Guidepost, 31 (12), 1-14.

Seibel, M.,& Murray, J. (1988). Early prevention of adolescent suicide. Educational Leadership, ? (3), 49-51.

Sheeley, V.L., & Herlihy, B. (1989). Counseling suicidal teens: A duty to warn and protect. The School Counselor, 37 (2), 89-97.

Smith, J. (1988). Tackling the tough issues in school based suicide awareness programs. (Report No. C6021163). Washington, D.C: AAS Conference. (Eric Document Reproduction Service No. ED 299517).

Valente, S.M., Saunders, J., & Street, R. (1988). Adolescent bereavement following suicide: An examination of relevant literature. Journal of Counseling and Development, 67 (3), 174-177.

Woodruff, J. (1987). An educator's guide to the literature dealing with adolescent suicide. (Report No. C6020611). South Bend, Indiana: (Eric Document Reproductive Service No. Ed 292 004).

_____ (1988). Responding to teenage suicide: The first 48 hours. Phi Delta Kappa Newsletter, 33 (1), 12-13.